March 30, 2000

Ms. Liz Trias
Health Care Financing Administration, Region X
Mail Stop 43
2201 Sixth Avenue
Seattle, WA 98121

Dear Ms. Trias:

Enclosed is the State Evaluation and FY 1999 Annual Report for the State of Oregon
Children's Health Insurance Program. Our office has used the National Association
of State Health Plan framework to fulfill the requirements of the Report and
Evaluation. This Evaluation will assist HCFA in assessing the progress Oregon has
made in its efforts to expand health care coverage to low-income children.

Per your conversation with Allison Knight, this report is being submitted to the Region
X office for distribution to the national HCFA office in Maryland. Please contact
Allison at (503) 945-6958 if you have any questions regarding this evaluation.

Sincerely,

Herschel Crawford
Director

FRAMEWORK FOR STATE EVALUATION
OF CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: _____ Oregon _____
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the
Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)

Date _____ March 30, 2000 _____

Reporting Period _____ July 1, 1998 - September 30, 1999 _____

Contact Person/Title _____ Allison Knight , Quality Improvement Program Coordinator

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_____ Salem, OR 97310 _____

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List of Acronyms

CAHPS	Consumer Assessment of Health Plan Study
CQI	Continuous Quality Improvement
DHS	Oregon Department of Human Services, formerly Department of Human Resources
ENCC	Exceptional Needs Care Coordination
EPSDT	Early & Periodic Screening Diagnostic and Treatment
EQRO	External Quality Review Organization
FCHP	Fully Capitated Health Plan
FFS	Fee-For-Service
FHIAP	Family Health Insurance Assistance Program
FPL	Federal Poverty Level
HCFA	Health Care Financing Administration
HEDIS	NCQA's Health Plan Employer Data Set
MCO	Managed Care Organization
MHO	Mental Health Organization
NCQA	National Committee for Quality Assurance
OADAP	Office of Alcohol and Drug Abuse Programs
OHP	Oregon Health Plan
OOHPPR	Office for Oregon Health Plan Policy and Research
OMAP	Office of Medical Assistance Programs
OPS	Oregon Population Survey
OYA	Oregon Youth Authority
PCCM	Primary Care Case Management
PCP	Primary Care Practitioner
PHP	Prepaid Health Plan
PLM	Poverty Level Medicaid
PP	Project: **PREVENTION!**
PSU	Portland State University
RWJ	Robert Wood Johnson Foundation
SCF	Services to Children and Families
TPA	Third Party Administrator

Section 1. Summary of Key Accomplishments of Your CHIP Program

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1   What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

	Children ≤19 Yrs
Estimated Uninsured	79,099
Estimated CHIP eligible	22,662

1.1.1   What are the data source(s) and methodology used to make this estimate?

These estimates were created using the Oregon Population Survey (OPS) (1998) and population estimates from the Portland State University (PSU) Center for Population Research and Census. First, estimates of the proportion of children in each income range (by Federal Poverty Level - FPL) and age category were calculated using the OPS. Then, within each income cohort, the proportion of kids with and without health insurance was estimated, by age group. Finally, these estimated proportions were applied to the PSU estimate of the number of kids in each age category to arrive at an estimated number of uninsured children in each category. These estimates were benchmarked against the previous 1996 estimates to ensure a sense of "rational trends".

1.1.2   What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The estimates are no more than +/-4% given a 95% confidence interval.

1.2   How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

Oregon has made substantial progress in expanding access to health care through a combination of public and private efforts. In 1991, according to the OPS, 21% of Oregon's children were uninsured, by 1998 that rate had been reduced to 9.5%. Uninsurance estimates for 2000 using the same research methodology will be available Fall 2000.

Oregon's CHIP program has made substantial progress in covering eligible uninsured children. Two-thirds (67.7%) of the estimated children eligible for CHIP are currently covered. Since the program started July 1, 1998, more than 28,000 children have been covered. The number of children served by the State's public health insurance programs, CHIP, Medicaid and Family Health Insurance Program (FHIAP), has increased 10% since 1997.

See table 1.2.A & 1.2.B

1.2.1   What are the data source(s) and methodology used to make this estimate?

Enrollment figures were collected from Medicaid/CHIP enrollment data. The uninsurance estimates were calculated using the methodology described in section1.1.1.

1.2.2   What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

See 1.1.2

TABLE 1.2-A
CHIP Enrollment, Uninsurance Rates by Region

Region--Counties	Est. CHIP Elig 1998	CHIP Enrolled Sep 1999	% CHIP Enrolled Sep 1999	Ever Enrolled 9/30/99	% CHIP Ever Enr 9/30/99
Metro-Clackamas, Multnomah, Washington, Yamhill	7377	5548	75.2%	10100	136.9%
N. Coast-Clatsop, Columbia, Lincoln, Tillamook	1015	813	80.1%	1391	137.0%
Willamette Valley-Benton, Lane, Linn, Marion, Polk	5541	3981	71.8%	7451	134.5%
Mid-Columbia-Gilliam, Hood River, Morrow, Sherman, Umatilla, Wasco, Wheeler	788	708	89.8%	1370	173.9%
Central-Crook, Deschutes, Jefferson	1194	812	68.0%	1527	127.9%
Southeast-Grant, Harney, Klamath, Lake	863	522	60.5%	1110	128.6%
Southern-Coos, Curry, Douglas, Jackson, Josephine	4959	2451	49.4%	4459	89.9%
Northeast- Baker, Malheur, Union, Wallowa	925	505	54.6%	959	103.7%
Total	**22662**	**15340**	**67.7%**	**28367**	**125.2%**

Table: 1.2-B
Oregon Health Plan (OHP)
Children Enrollment 1997 - 1999

	9/30/97	9/30/98	9/30/99
Medicaid	168,442	166,959	169,012
CHIP	0	6,250	15,173
FHIAP	0	n/a	2,066
Total	168,442	173,209	186,251
% Change Since 1997		3%	11%

Source: Office of Medical Assistance Programs

1.3 **What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?**

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

| Objective 1 **Expand OHP eligibility rules to include uninsured children living in households with incomes that fall within:**

100-170% FPL children 6 through 18 years

133-170% FPL children birth through age 18

*Children under 6 years living in households between 100-133% of FPL are eligible for OHP coverage through the Poverty Level Medicaid (PLM) program. | **Performance Goal for Objective 1** By July 1, 1998 the Office of Medical Assistance Programs (OMAP) will expand the capacity of the OHP to meet the needs of 17,000 CHIP eligibles. OMAP's data and operational systems will be structured to accommodate CHIP criteria in the areas of eligibility determination, enrollment, client information and utilization of health care services. OMAP staff and Department of Human Services (DHS) field personnel will receive CHIP related training. | Data Sources: n/a

Methodology: n/a

Numerator: n/a

Denominator: n/a

Progress Summary:

Accomplished on time according to plan as specified in Performance Goal for Objective 1. |

Objective 2 Identify CHIP eligibles through coordinated and ongoing outreach activities.	Performance Goal for Objective 2 By January 1, 1999 OMAP will develop and implement outreach efforts among current Medicaid OHP channels to identify, enroll and meet the health care needs of the CHIP population.	Data Sources: n/a Methodology: n/a Numerator: n/a Denominator: n/a Progress Summary: OMAP hosted a meeting in April of 1998 with community advocates, health professionals and government officials to discuss outreach activities for the CHIP program and OHP Medicaid. An enhanced OMAP outreach program began in conjunction with the implementation of CHIP on July 1, 1998 and was largely based upon the outcomes of the April meeting. The following activities occurred to implement the outreach program: • OMAP identified potential outreach facilities as the following types: • County Health Departments • Hospitals • Rural Health Clinics • Migrant Health Centers • Federally Qualified Health Centers • Family Planning Clinics • Tribal Health Clinics

Objective 3	Performance Goal for Objective 3	Data Sources: Medicaid/CHIP enrollment files
Enroll CHIP eligibles in the OHP health care delivery system to assure a usual source of health care coverage.	By July 1, 1999, 16,800 low income children will be enrolled in Oregon's CHIP. They will have access to a usual source of health care coverage in the form of a stable health care plan and an assigned primary care provider.	**Methodology:** The number of children enrolled in CHIP as of January 1, 1999. **Numerator:** See Table 1.3-A **Denominator:** See Table 1.3-A **Progress Summary:** Oregon's CHIP enrollment was slightly slower than expected. As of September 30, 1999 15,173 children were enrolled in CHIP. However, 28,367 children have been enrolled any one time since the program began in July 1998. Through 9/30/99, nearly 13,000 children have disenrolled. This higher than expected disenrollment rate of approximately 4,000 children per quarter has been the most significant factor in not meeting Oregon's estimated enrollment target. Nearly one-half (46%) of children who disenrolled, enroll in Medicaid the following quarter.

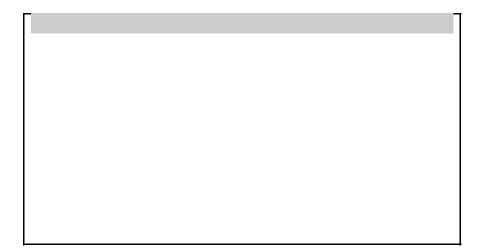| Objective 4	Performance Goal for Objective 4	Data Sources: Encounter Data Files, Claims Files, Medicaid/CHIP enrollment files
Monitor access and utilization patterns among CHIP enrollees.	By July 1, 1998, CHIP enrollees will be assigned a unique code that will enable OMAP analysts to distinguish CHIP clients from the OHP Medicaid population. OMAP will monitor CHIP utilization patterns to help assure access to health care and the delivery of medically appropriate care.	Methodology: Modified Health Plan Employer Data Information Set (HEDIS) Access to Primary Care Provider Numerator: see Table 1.3-B Denominator: see Table 1.3-B Progress Summary:

Unique CHIP codes are assigned to children when they enroll in CHIP. All OHP enrollment history (CHIP and Medicaid); Managed Care Organization (MCO) enrollment; as well as claims and encounter data is collected. This information allows OMAP to track children's enrollment in CHIP and Medicaid and their use of services.

The reported figures are estimated to be slightly under-reported due to encounter data omissions. Because of the newness of the program, the denominator consisted of children who were continuously enrolled in an OHP Fully Capitated Health Plan (FCHP) and eligible for CHIP any time in 1998.

Our data indicate that in 1998, 82% of Oregon CHIP enrollees (all ages) who were continuously enrolled in OHP received at least one visit to a Primary Care Practitioner. This compares favorably to National Committee for Quality Assurance (NCQA) Quality Compass rate of 80.3% to 89.9%[1]

Objective 5	Performance Goal for Objective 5	Data Sources: Medicaid/CHIP enrollment data, Encounter Data, Claims Data

Improve the health status of CHIP enrollees through provider and client programs specific to the needs of this population.	By July 1, 1999, the following health status and health care system measures for Oregon's CHIP enrollees will be collected and analyzed to demonstrate acceptable incremental improvement in the following areas: childhood and adolescent immunization status, well child and adolescent well care visits, early childhood caries prevention and treatment, treating children's ear infections, and client satisfaction with access to, choice of and quality of health care.	**Methodology:** Modified HEDIS 3.0, 1999
		
		Numerator: See Table 2.3-C
		
		Denominator: See Table 2.3-C
		
		Progress Summary:
		See Table: 1.3-C
		  Oregon's encounter data indicate the rate for well child visits for 3 to 6 year olds is 33%. When the 46%[2] adjusted figure is used, well-visits remain below OMAP's targeted Healthy People 2000 Goal of 80%, however this figure is comparable to NCQA' Quality Compass rate of 51% nationally.
		  -care visits for children and adolescents are a focus of OHP's upcoming 2000/2001 cycle of on-site, MCO quality improvement evaluations. Increasing the number of children and adolescents receiving well-care visits, as well as improving the quality of the visit will be the objective of these on-site evaluations.
		  The reported figures are estimated to be under-reported due to encounter data omissions. Because of the newness of the program, the denominator consisted of children who were continuously enrolled in an OHP FCHP (as defined by HEDIS) and eligible for CHIP any time in 1998.
		  Because of the newness of the program, the denominator consisted of children who were continuously enrolled in an OHP FCHP (as defined by HEDIS)

Table 1.3-A
CHIP Disenrollees
Number of CHIP Disenrolled by Quarter
Program Status Following Quarter

Following Quarter	Qtr End 12/31/99	Qtr End 3/31/99	Qtr End 6/30/99	Qtr End 9/31/99	Total	Rate
Medicaid	454	1829	1933	1613	5829	45.8%
Not CHIP, Not Medicaid	236	2131	2052	2467	6886	54.2%
Total CHIP Disenrolled	690	3960	3985	4080	12715	

Source:
Office of Medical Assistance
Programs

Table 1.3-B
Rate of Primary Care Visits

	# of Children All Ages Continuously Enrolled	# of Children All Ages Receiving Primary Care Visits	% Receiving Primary Care
CHIP	1673	1376	82%
OHP Total	43457	34717	80%

Table 1.3-C Rate of Well-Child Visits: 3 to 6 Years	# of Children 3 to 6 Years Continuously Enrolled	# of Children 3 to 6 Years Receiving Well- Child Care Visits	% Receiving Well-Child Visits
CHIP	562	188	33%
OHP Total	16259	6203	38%

Section 2.   Background

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1   How are Title XXI funds being used in your State?

    2.1.1   List all programs in your State that are funded through Title XXI. (Check all that apply.)

        ___   **Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)**

            Name of program: _____

            Date enrollment began (i.e., when children first became eligible to receive services): _____

        _X_   **Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)**

            Name of program: ___CHIP_____
            Date enrollment began (i.e., when children first became eligible to receive services): _____7/1/98_____

        ___ **Other - Family Coverage**

            Name of program: _____

            Date enrollment began (i.e., when children first became eligible to receive services): _____

        ___ **Other - Employer-sponsored Insurance Coverage**

            Name of program:

            Date enrollment began (i.e., when children first became eligible to receive services):

        ___ **Other - Wraparound Benefit Package**

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

____ **Other (specify**) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

  2.1.2 If State offers family coverage: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

  2.1.3 If State has a buy-in program for employer-sponsored insurance: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.2   What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

  2.2.1   How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Oregon's Medicaid program operates under an 1115 waiver. Oregon's CHIP program was designed to be seamless with the 1115 Medicaid Waiver. A single application and eligibility determination process and quality improvement program are used for both CHIP and Medicaid. Services are received under the same delivery system for CHIP and Medicaid. Benefit package is nearly identical. As with Medicaid for children, no co-pays or premiums are charged for Oregon's CHIP program.

The 1997 Oregon Legislature created the Family Health Insurance Assistance Program (FHIAP), a public-private partnership that subsidizes health insurance benefits coverage for Oregonians who are currently uninsured. It is designed to use Oregon's existing private health insurance system. This program, which began July 1998, provides direct subsidies to uninsured, low-income (up to 170% FPL, uninsured for six months-- consistent with CHIP requirements), working people who cannot afford to buy health insurance through their employers or through the individual market who are not receiving benefits under the Medicaid program. The FHIAP program emphasizes coverage for children. Parents in families may not use the subsidy strictly for themselves if the child is uninsured.

The FHIAP outreach process is coordinated with the Medicaid/CHIP outreach process. A Third Party Administrator (TPA) notifies all people who ask to be placed on FHIAP's reservation list of potential CHIP or Medicaid eligibility.

2.2.2   Were any of the preexisting programs "State-only" and if so what has happened to that program?

___   No pre-existing programs were "State-only"

X   One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

The Medicaid 1115 waiver is still in effect in Oregon and still enrolling children. See Section 2.2.1

2.2.3   Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

X   **Changes to the Medicaid program**

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
___ Provision of continuous coverage (specify number of months ___)
___ Elimination of assets tests
___ Elimination of face-to-face eligibility interviews
___ Easing of documentation requirements
X   Other

The asset limit for households was reduced from $5000 to $2000.

___ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)_____

X   **Changes in the private insurance market that could affect affordability of or accessibility to private health insurance**

X   Health insurance premium rate increases
___ Legal or regulatory changes related to insurance

___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)

___ Changes in employee cost-sharing for insurance

X   Availability of subsidies for adult coverage

___ Other (specify) _____

X   Changes in the delivery system

     X   Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)

     ___ Changes in hospital marketplace (e.g., closure, conversion, merger)

     ___ Other (specify) _____

X   Development of new health care programs or services for targeted low-income children (specify)

In July 1998, FHIAP began enrolling low income individuals and families.

___ Changes in the demographic or socioeconomic context

     ___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____

     ___ Changes in economic circumstances, such as unemployment rate (specify)_____

     ___ Other (specify)_____

     ___ Other (specify) _____

SECTION 3.   PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1   Who is eligible?

    3.1.1   Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1			
	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program*** ___
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))		State of Oregon	
Age		<19 years	
Income (define countable income)		3 Months household gross income 134-170% FPL birth through 18 years 101-170% FPL age 6 through 18 years* *children under 6 years living in households between 101-133% FPL are eligible for OHP coverage	
Resources (including any standards relating to spend downs and disposition of resources)		$5,000 household liquid assets (cash, checking, savings, stocks, bonds, IRAs, etc)	

Residency requirements		Oregon resident or qualified resident alien	
Disability status		N/A	
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))		Not covered by other creditable health coverage, other than OHP/Medicaid, for at least 6 months prior to application.	
Other standards (identify and describe)_____		Eligibility is retroactive to date of application request	

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly		NA	
Every six months		X	
Every twelve months		NA	
Other (specify)_____			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 **Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))**

X   Yes ° Which program(s)? OMAP CHIP

For how long?   6 Months
___ No

3.1.4 **Does the CHIP program provide retroactive eligibility?**

___ Yes ° Which program(s)?

How many months look-back? Up to 45 days from date of application

X No   CLARIFYING DEFINITION USED WITH HCFA

3.1.5 **Does the CHIP program have presumptive eligibility?**

___ Yes ° Which program(s)?

Which populations?

Who determines?
X   No

3.1.6 **Do your Medicaid program and CHIP program have a joint application?**

X   Yes ° Is the joint application used to determine eligibility for other State programs?
    If yes, specify.

Not currently used for any other state programs.

___ No

3.1.7   Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

Table 3.1.7

	Program Design	Strength	Weakness
Application Process	Mail-in application.	Avoids the need for in-person interviews	
	No income deductions or withholds on application	Easy income calculation	
	Application packet	Short, 4-page application form. Contains useful information about managed care.	Entire application packet contains 12 items, may be confusing to applicants. Questions may be confusing to applicants
	Single OHP application for CHIP and Medicaid	Seamless coverage for mixed eligibility families and families that move into and out of CHIP and Medicaid	Applicants may perceive CHIP as "welfare" Because entire household is listed on application, children cannot be targeted exclusively.
	Toll-Free hotline for application request and assistance	Convenience	Some applicants do not have phone service.

	Program Design	Strength	Weakness
	Enabling services	Application available in 9 languages. Spanish speaking representatives available at hotline and application center. Language translation services available through AT&T interpreter services.	
	Verification	Program designed to reduce fraud and abuse.	Applicant must submit copies of Social Security cards for all members of household (if available) and 3-months income documentation.
	125 Outreach Sites	Trained outreach workers at sites throughout the State assist families in the application process.	Limited to specific types of facilities.

	6-month uninsurance requirement	Program designed to expand coverage to children who are uninsured and avoid substitution of public insurance for private insurance. Approximately 90% of children who are found ineligible because of this requirement have current health coverage.
		  Exceptions for children with immediate health care needs.
		  Exception for children covered by Medicaid.
			A small number of children will lack health care coverage to meet the 6-month requirement.

	Program Design	**Strength**	**Weakness**
Eligibility	Same staff determine CHIP and Medicaid eligibility	Seamless process, decreased administrative burden. Applicants automatically screened first for Medicaid eligibility. CHIP and Medicaid enrollees are included in the same case.	
	6-month guaranteed eligibility	Reduced burden on applicant to prove eligibility during this period. "Medical home" assured for 6-months.	See narrative.
Eligibility Re-determination	3 notices sent to applicant before coverage ends. MCO's may advise OMAP of ending coverage Application sent with notice.	Applicant notified a number of times before coverage ends to prevent lapses in coverage. Client does not need to request another application.	
	Reapply through process listed above		

Oregon designed its CHIP program to be "seamless" with the OHP Medicaid waiver program. The CHIP application, eligibility determination and redetermination process is fully integrated within the Medicaid operations. The OHP application processing center receives between 17,000 and 20,000 applications per month which represents approximately 90% of all OHP applications (the remaining applications are processed at the branch level). By using the same application for Medicaid and CHIP, families are often unaware that they may be applying for two distinct programs. This streamlines the process for both OHP clients and the OHP application processing center.

An Enhanced Verification process has been implemented in order to reduce fraud in the Medicaid system. These EV measures include the requirement to provide three months of the most recent income statements and copies of Social Security cards for all household members. These requirements may discourage some eligible people from applying for coverage.

Approximately two-thirds of CHIP enrollees lose eligibility at the time of redetermination after six months. This would indicate that household incomes fluctuate often. Approximately one-half of those who disenroll from CHIP enroll in Medicaid the following quarter, thereby continuing their OHP coverage.

Because of the high rate of fluctuation in family income identified at the time of eligibility redetermination, Oregon's six-month guaranteed eligibility would appear to reduce the expenditure of CHIP funds on non-CHIP eligible children (i.e. Medicaid eligible and over-income children) compared to a 12-month guaranteed eligibility period. This has resulted in more program turnover, while covering children who are truly CHIP eligible. If eligibility was guaranteed for twelve months as opposed to six, CHIP would have met the enrollment limit of 16,800 and closed the program nearer to the time frame originally estimated. A longer guaranteed enrollment period would increase continuity of access to care for these children.

One factor that may play a role in a parent's decision to apply for CHIP coverage for their children is adult premium arrearage. The OHP 1115 Medicaid waiver covers an expansion population up to 100% FPL. This "newly eligible" adult population is charged a small premium, between $6 to $23 per month per household. Because the OHP CHIP and Medicaid are seamless, parents who have OHP premiums in arrearage may be less likely to apply for coverage for their children, even though their children can receive Medicaid and CHIP regardless of premiums the parent may have in arrearage.

> **3.1.8   Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?**

See Section 3.1.7

3.2   What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1   Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost-sharing (if any), and benefit limits (if any).

Table 3.2.1   CHIP Program Type_____

Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	Yes	None	Inpatient services medically necessary for the treatment of health condition and treatment pairs listed on the Oregon Health Plan Prioritized List and funded by the State of Oregon Legislature are covered. Non-emergency inpatient hospital services provided by managed care plans may be subject to limitations and/or prior authorization. Selected non-emergency inpatient hospital services for fee-for-service clients may be subject to pre-admission screening for medical necessity. Such screening will be accomplished by a professional medical review organization or OMAP. Coverage, prior authorization and limitations on inpatient hospital services are documented in the OMAP's Hospital Services for the Oregon Health Plan Guide.
Emergency hospital services	Yes	None	Outpatient services medically necessary for the treatment of health condition and treatment pairs listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered. Some non-emergency outpatient hospital services provided by managed care plans may be subject to limitations and/or prior authorization. Fee-for-service, non-emergency outpatient hospital services may be subject to limitations and/or prior authorizations as documented in OMAP's Hospital Services for the Oregon Health Plan Guide.

Table 3.2.1   CHIP Program Type_____

Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Outpatient hospital services	yes	no	Outpatient services medically necessary for the treatment of health condition and treatment pairs on the OHP Prioritized List and funded by the legislature are covered. Some non-emergency outpatient hospital services provided by managed care plans may be subject to limitations and/or prior authorization. Fee-for-service, non-emergency outpatient hospital services may be subject to limitations and/or prior authorizations as documented in OMAP's Hospital Services for the Oregon Health Plan Guide.
Physician services	yes	no	Physician's services necessary to diagnose any medical condition are covered. Once a condition is diagnosed, physician services are limited to those services that are medically necessary for the treatment of health condition and treatment pairs listed on the OHP Prioritized listed and funded by the State of Oregon Legislature. Fee-for-service, physician services may be subject to limitations and/or prior authorizations as documented in OMAP's Medical-Surgical Services Guide
Clinic services	yes	no	Clinic services that are medically necessary for the treatment of health condition and treatment pairs listed on the OHP Prioritized listed and funded by the State of Oregon Legislature.
Prescription drugs	yes	no	Prescription drugs medically necessary for the treatment of health condition and treatment pairs listed on the OHP Prioritized listed and funded by the State of Oregon Legislature. Some prescriptions may require prior authorization by the client's FCHP, or from OMAP if the client is not in a managed care plan. A list of prescription drugs that require prior authorization for fee-for-service clients are documented in the OMAP Pharmaceutical Services Guide.
Over-the-counter medications	yes	no	Over the counter drugs medically necessary for the treatment of health condition and treatment pairs listed on the OHP Prioritized listed and funded by the State of Oregon Legislature. Some prescriptions may require prior authorization by the client's FCHP, or from OMAP if the client is not in a managed care plan. A list of over-the-counter medications that require prior authorization for fee-for-service clients are documented in the OMAP Pharmaceutical Services Guide.

Table 3.2.1   CHIP Program Type_____

Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Outpatient laboratory and radiology services	yes	no	Laboratory and radiological services for the purpose of establishing a diagnosis are covered. Once a diagnosis has been determined, laboratory and radiological services medically necessary for the treatment of health condition and treatment pairs listed on the OHP Prioritized listed and funded by the State of Oregon Legislature.
Prenatal care	yes	no	Prenatal care provided by managed care plans may be subject to limitations and/or prior authorization. Some fee-for-service prenatal services may be subject to limitations and/or prior authorizations as documented in the OMAP Medical-Surgical Guide. Pre-pregnancy services and supplies can be provided by any health care provider if within his or her scope of practice as defined in Oregon Revised Statutes, subject to limitations set forth in the OMAP Medical-Surgical Guide and Pharmaceutical Guide. Clients in managed care plans may obtain pre-pregnancy services from a plan provider or from any other OMAP registered provider functioning within his/her scope of practice.
Family planning services	yes	no	Family planning services are available to individuals of childbearing age who desire such services. Services included are those intended to prevent or delay pregnancy or otherwise control family size. Counseling services, laboratory tests, medical procedures and pharmaceutical supplies and devices are covered if provided for family planning purposes.
Inpatient mental health services	yes	no	Inpatient hospital mental health services medically necessary for the treatment of health condition and treatment pairs listed on the Oregon Health Plan Prioritized List and funded by the State of Oregon Legislature are covered. Non-emergency inpatient mental health services require prior authorization of the client's MHO. Residential psychiatric treatment programs are covered.

Table 3.2.1   CHIP Program Type

Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Outpatient mental health services	yes	no	Outpatient mental health services medically necessary for the treatment of health condition and treatment pairs listed on the Oregon Health Plan Prioritized List and funded by the State of Oregon Legislature are covered. According to the MHO's protocols, prior authorization may be required. Psychological services and evaluations are also covered under the state of Oregon's School-Based Health Services Program, as documented in OMAP's School-Based Health Services Guide.
Inpatient substance abuse treatment services	yes	no	Residential treatment in a structured 24-hour supervised treatment and care facility is covered.
Residential substance abuse treatment services	yes	no	See Inpatient substance abuse treatment services.
Outpatient substance abuse treatment services	yes	no	Outpatient substance abuse treatment services are covered and must be provided in Office of Alcohol and Drug Abuse Programs (OADAP) approved facilities and meet OADAP approved treatment criteria.
Durable medical equipment	yes	no	DME and related services, necessary to maintain the least restrictive environment and foster independence of the client, and medically necessary for the treatment of health condition and treatment pairs listed on the Oregon Health Plan Prioritized List and funded by the State of Oregon Legislature are covered. DME, eyeglasses, hearing aids and augmented communication devices provided may be subject to limitations and/or prior authorization requirements from MCOs or OMAP in the case of fee-for-service clients as documented in OMAP's Durable Medical equipment and Medical Supplies Guide, Visual Services Practitioner's Guide, respectively. Vision evaluation and services are also covered under Oregon's School-Based Health Services Program, as documented in the OMAP School Based Health Services Guide.

Table 3.2.1   CHIP Program Type_____

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Disposable medical supplies	yes	no	Disposable medical supplies for the use by clients in their own homes are covered when medically necessary for the treatment of health condition and treatment pairs listed on the Oregon Health Plan Prioritized List and funded by the State of Oregon Legislature. Disposable medical supplies may be subject to limitations and/or prior authorization requirements from MCOs or OMAP in the case of fee-for-service clients as documented in the OMAP Home Health Services Guide. Personal care services limited to medically oriented tasks, such as assisting with personal hygiene, dressing, feeding, and transfer and ambulation needs are covered if the services are prescribed by a physician or authorized by the state in accordance with a plan of treatment, provided by an individual qualified to provide such services, and furnished in a home.
Preventive dental services	yes	no	Preventive services include: oral prophylaxis, radiographs, topical fluoride and sealants.
Restorative dental services	yes	no	Restorative services include: restorations for primary and permanent teeth using amalgam, composite materials and stainless steel or polycarbonate crowns.
Hearing screening	yes	no	Hearing screening exams are included in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, offers well-child medical exams with referral for medically necessary comprehensive diagnosis and treatment for all children (birth through age 20).
Hearing aids	yes	no	Two binaural hearing aids will be reimbursed no more frequently than every three years for children who meet the criteria in the OMAP Speech-Language Pathology, Audiology and Hearing Aid Services guide.
Vision screening	yes	no	Vision screening exams are included in the EPSDT program, offer well-child medical exams with referral for medically necessary comprehensive diagnosis and treatment for all children (birth through age 20).

Table 3.2.1   CHIP Program Type

Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Corrective lenses (including eyeglasses)	yes	no	Medically necessary corrective lenses are covered as documented in the OMAP Vision Services Guide.
Developmental assessment	yes	no	A comprehensive health and developmental history including assessment of both physical and mental health development is included in the EPSDT program, offers well-child medical exams with referral for medically necessary comprehensive diagnosis and treatment for all children (birth through age 20). If, during the screening process, a medical or mental health condition is discovered the client may be referred to the appropriate medical providers or Mental Health and Developmental Disability Services Division, for further diagnosis and/or treatment.
Immunizations	yes	no	All age appropriate immunizations are included as specified by ACIP.
Well-baby visits	yes	no	All age appropriate well-baby visits are covered.
Well-child visits	yes	no	All age appropriate well-child visits are covered.
Physical therapy	yes	no	Physical therapy services as described in the OMAP Physical Therapy guide in accordance to the plan of treatment of health conditions listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered. OMAP will reimburse for the lowest level of service that meets the medical need. Therapy is based on a prescribing practitioner's written order and a therapy treatment with goals and objectives developed from an evaluation/reevaluation. The therapy regimen will be taught to patient, family and/or care giver to assist in the achievement of the goals and objectives. Therapy that becomes maintenance is not a covered service

Table 3.2.1 CHIP Program Type_____

Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Speech therapy	yes	no	Speech therapy services as described in the Speech-Language, Audiology & Hearing Aid Services guide in accordance to the plan of treatment of health conditions listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered. OMAP will reimburse for the lowest level of service that meets the medical need. Therapy is based on a prescribing practitioner's written order and a therapy treatment with goals and objectives developed from an evaluation/reevaluation. The therapy regimen will be taught to patient, family and/or care giver to assist in the achievement of the goals and objectives. Therapy that becomes maintenance is not a covered service.
Occupational therapy	yes	no	Occupational therapy services as described in the Physical and Occupational Therapy Service guide and in accordance to the plan of treatment of health conditions listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered. OMAP will reimburse for the lowest level of service that meets the medical need. Therapy is based on a prescribing practitioner's written order and a therapy treatment with goals and objectives developed from an evaluation/reevaluation. The therapy regimen will be taught to patient, family and/or care giver to assist in the achievement of the goals and objectives. Therapy that becomes maintenance is not a covered service.
Physical rehabilitation services	yes	no	Physical therapy services as described in the Physical and Occupational Therapy Service guide and in accordance to the plan of treatment of health conditions listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered. OMAP will reimburse for the lowest level of service that meets the medical need. Therapy is based on a prescribing practitioner's written order and a therapy treatment with goals and objectives developed from an evaluation/reevaluation. The therapy regimen will be taught to patient, family and/or care giver to assist in the achievement of the goals and objectives. Therapy that becomes maintenance is not a covered service.
Podiatric services	yes	no	Podiatrist's services within the scope of practice are covered for the treatment of health conditions listed on the OHP Prioritized List and funded by the State of Oregon Legislature.

Table 3.2.1 CHIP Program Type_____

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Chiropractic services	yes	no	Chiropractic services as described in the OMAP Chiropractic Services Practitioner's Guide and in accordance to the plan of treatment of health conditions listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered. A referral from the client's managed care plan may be necessary.
Medical transportation	yes	no	Medical Transportation services as described in the OMAP Medical Transportation Services guide and in accordance to the plan of treatment of health conditions listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered.
Home health services	yes	no	Home health care services according to a plan of treatment for the treatment of health conditions listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered. Services provided managed care plans may be subject to limitation and/or prior authorization. Services for fee-for-service clients may be subject to limitation and/or prior authorization as documented in the OMAP Home Health Services Guide. Personal care services limited to medically oriented tasks, such as assisting with personal hygiene, dressing, feeding and transfer and ambulation needs are covered if the services are prescribed by a physician or authorized by the state in accordance with a plan of treatment, provided by an individual qualified to provide such services, and furnished in a home.
Nursing facility	yes	no	Nursing facility services medically necessary for the treatment of health conditions listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered. Nursing facility services provided managed care plans may be subject to limitation and/or prior authorization. Nursing facility services for fee-for-service clients may be subject to limitation and/or prior authorization as documented in the OMAP Hospital Services Provider Guide.

*Table 3.2.1   CHIP Program Type*_____

Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
ICF/MR	yes	no	ICF services medically necessary for the treatment of health conditions listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered. ICF services provided managed care plans may be subject to limitation and/or prior authorization. ICF services for fee-for-service clients may be subject to limitation and/or prior authorization as documented in the OMAP Hospital Services Provider Guide.
Hospice care	yes	no	Hospice care is covered. Requirement for coverage of hospices is documented in the OMAP Hospice Program Rules
Private duty nursing	yes	no	Nursing care services medically necessary for the treatment of health conditions listed on the OHP Prioritized List and funded by the State of Oregon Legislature are covered. Nursing services provided managed care plans may be subject to limitation and/or prior authorization. Nursing services for fee-for-service clients may be subject to limitation and/or prior authorization as documented in the OMAP Private Duty Services Guide and the Medically Fragile In-Home Supports Oregon Administrative Rules.
Personal care services	yes	no	See Home Health Services, Private Duty Nursing
Habilitative services	yes	no	See Physical Therapy, Occupational Therapy and Speech Therapy

Table 3.2.1   CHIP Program Type_____

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Case management/Care coordination	yes	no	Exceptional Needs Care Coordination (ENCC) and targeted case management services are covered services for specific populations.. The ENCC program covers children receiving services through SCF (foster care), the Oregon Youth Authority (OYA) and Senior & Disabled Services Division. MCO's are required to identify and offer ENCC services to children and adults with complex medical needs. ENCC services include assistance to ensure timely access to services, coordination and assistance with providers, and aid with coordinating community support and social service systems linkage with medical care systems.
			The purpose of targeted case management is to coordinate and assure access to and delivery of services to specific populations. Services include:
			Screening: identification of the client as an individual in need of targeted case management services.
			Assessment: the systematic, ongoing gathering of information to the client's physical, environmental, psycho social, developmental, educational and emotional needs.
			Case Plan Development: identification of client-specific needs, development of written goals, and identification of resources to meet the client's needs in a coordinated and integrated manner.
			Intervention/Implementation: implementation and monitoring of the client's case plan including referral to appropriate agencies and services identified in the case plan. The case manager is responsible for facilitating implementation of agreed-upon services by assisting the client in accessing the services and assuring that the client fully understands how these services support the case plan.
			Evaluation: periodic reassessment of the client's status and needs, review and update of the care plan, determination of whether goals are being met, review and update of the appropriateness of actions and referrals and accurate record keeping.

Table 3.2.1   CHIP Program Type_____

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Non-emergency transportation	yes	no	Non-emergency transportation to medical, dental and mental health services is covered and requires prior authorization by the FCHP or OMAP if not enrolled in a managed care plan. The OMAP Transportation Guide describes covered services. Transportation to obtain School-Based Health Services as documented in the rules and procedures set forth in the OMAP School-Based Health Services Provider Guide is covered.
Interpreter services	yes	no	MCO's are required to provide language translation of written informational materials for if the plan covers 35 or more households of the same language. MCO must provide interpreter services for services if no one in the household speaks English.
Other (Specify)_____			
Other (Specify)_____			
Other (Specify)_____			

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Comprehensive Coverage, Focus on Prevention
The Oregon Health Plan was implemented in 1994 with a Medicaid 1115 waiver with the goal of ensuring access to comprehensive and cost effective health care coverage focused on disease prevention to all low income Oregonians. To help offset the cost of covering more people, health care cost containment measures were implemented. These measures include mandatory enrollment in managed care plans and the establishment of a prioritized list of diagnoses and treatment pairs that covers treatment of effective interventions for conditions that would not get better on their own. Children enrolled in Oregon's CHIP program receive a comprehensive benefit package that includes case-management, preventive health care, interpreter and non-emergency transportation services at no additional cost.

Exceptional Needs Care Coordination, Case Management
In an effort to address the needs of children and adolescents with complex medical and social needs, Oregon developed the ENCC program to assist clients in obtaining medical, social, educational, and other services as outlined in Table 3.2.1.

Community Partnerships
Recognizing the social value of partnerships between county health departments, other publicly supported programs and health providers, health plans are encouraged to involve these providers in the development and implementation of their programs.

Coordination of Care
Coordination of services is addressed in the Prepaid Health Plan (PHP) contract. PHPs are required to coordinate services for each client who requires services from agencies providing health care services not covered under the Capitation Payment. The PCP shall arrange, coordinate and monitor other medical and mental health, and/or dental care for the client on an ongoing basis as specified by OHP Administrative Rules.

Client Education
Preventive Services promoting health and/or reducing the risk of disease are covered services. PHPs

shall have written procedures and criteria for health education of clients. Health education shall include: information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health, patient self-care, and disease and accident prevention. PHPs shall review preventive care on an annual basis.

Medical Home, Continuity of Care
Research conducted in 1998/1999 by Health Economics Research found that children enrolled in OHP are significantly more likely than uninsured children to have a usual source of care, to have used health services within the past year and to have received a routine medical checkup and dental visit. HER reported the above indicators at a comparable rate to privately insured Food Stamp recipients. OHP children were significantly more likely to have received a prescription in the past year than both uninsured and insured control groups. Few OHP parents reported that their child had an unmet need for specialist services (4%) or dental care (12%). Overall, no statistically significant differences in measures for health satisfaction were reported by parents of OHP children compared to those with private insurance. A majority of parents in both the privately insured (95.2%) and OHP (94%) groups reported that they were willing to recommend their usual place of care to others.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)		yes	
Statewide?	___ Yes ___ No	_x_ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	___ Yes ___ No	_x_ Yes ___ No	___ Yes ___ No
Number of MCOs		13 FCHPs 12 DCOs 13 MHOs 2 CDOs	
B. Primary care case management (PCCM) program		yes, if no FCHP available in area	
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)			
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)		yes, if no FCHP or PCCM available in area	
E. Other (specify)_____			
F. Other (specify)_____			
G. Other (specify)_____			

3.3   How much does CHIP cost families?

3.3.1   Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

    X   No, skip to section 3.4

    ___   Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
Other (specify) _____			

    *Make a separate column for each "other" program identified in section 2.1.1.   To add a column to a table, right click on the mouse, select "insert" and choose "column".
    **See Table 3.2.1 for detailed information.

3.3.2   **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3   **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

    ___   Employer
    ___   Family
    ___   Absent parent
    ___   Private donations/sponsorship

_____ Other (specify) _____

3.3.4   **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5   **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6   How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7   How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

    _____ Shoebox method (families save records documenting cumulative level of cost sharing)
    _____ Health plan administration (health plans track cumulative level of cost sharing)
    _____ Audit and reconciliation (State performs audit of utilization and cost sharing)
    _____ Other (specify)_____

3.3.8   What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9   Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4   How do you reach and inform potential enrollees?

3.4.1   What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (T=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Billboards						
Brochures/flyers			X	NA		
Direct mail by State/enrollment broker/administrative contractor						
Education sessions			X	4		
Home visits by State/enrollment broker/administrative contractor						
Hotline			X	4		
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Non-traditional hours for application intake			Mail in application	4		
Prime-time TV advertisements						
Public access cable TV						
Public transportation ads						
Radio/newspaper/TV advertisement and PSAs						
Signs/posters			X - 125 outreach facilities	Data available in June		
State/broker initiated phone calls						
Other (specify)_____						
Other (specify)_____						

3.4.2   **Where does your CHIP program conduct client education and outreach?**

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (T=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events						
Beneficiary's home						
Day care centers						
Faith communities						
Fast food restaurants						
Grocery stores						
Homeless shelters						
Job training centers						
Laundromats						
Libraries						
Local/community health centers			X	Data available June 2000		
Point of service/provider locations						
Public meetings/health fairs						
Public housing						
Refugee resettlement programs						

Table 3.4.2

	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
Schools, Adult Education Sites			X RWJ Covering Kids Pilot Projects	5		
Senior centers						
Social service agency			X	NA		
Workplace						
Other (specify) <u>Alcohol & Drug Program Centers</u>			X	Data available June 2000		
Other (specify) SEE OBJECTIVE #2 OR 3						

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

In January 2000, OMAP along with Adult and Family Services initiated a study to determine the percentage of applications originating from Outreach Facilities. The results of the study will be available June 2000.

3.4.4   What communication approaches are being used to reach families of varying ethnic backgrounds?

Most of the larger outreach centers employ workers that are bilingual in English and Spanish, as well as Russian in some instances. AT&T language translation services are available for most languages.

3.4.5   Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

NA

3.5   What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5				
Type of coordination	Medicaid*	Maternal and child health	Other (specify) _____	Other (specify) _____
Administration	X			
Outreach	X	X		
Eligibility determination	X			
Service delivery	X			
Procurement	X			

Type of coordination	Medicaid*	Maternal and child health	Other (specify) ___	Other (specify) ___
Contracting	X			
Data collection	X			
Quality assurance	X			
Other (specify) ___				
Other (specify) ___				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6   How do you avoid crowd-out of private insurance?

3.6.1   Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

Eligibility determination process:

X   Waiting period without health insurance (specify)_

A 6 month waiting period without private health insurance is required. Children with life threatening or disabling health conditions are exempted from this requirement.

X   Information on current or previous health insurance gathered on application
___ Information verified with employer (specify) _____
___ Records match (specify) _____
___ Other (specify) _____
___ Other (specify) _____

___ Benefit package design:

___ Benefit limits (specify) _____
___ Cost-sharing (specify) _____
___ Other (specify) _____
___ Other (specify) _____

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify) ————————————————————————————————

___ Other (specify) ————————————————————————————————

3.6.2   How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

The identification of children who are currently covered under private health insurance is addressed in the application and eligibility determination process. If the applicant reports that they have been enrolled in private insurance within the past 6 months, they are not eligible for CHIP coverage. Oregon does exempt children who have life threatening or disabling conditions from this requirement. An informal study conducted by OMAP in 1999, indicated that very few (approximately 34 per month) "CHIP" applications are denied solely because of the "crowd-out" requirement. Of the children that were denied due to private insurance coverage within the past six months, almost all (>90%) were currently insured.

In an effort designed to support partnerships between the public and private sector, the Family Health Insurance Assistance Program (FHIAP) is a premium subsidy program to low-income, families under 170% of the FPL. FHIAP was implemented at the same time as CHIP. FHIAP requires that all children in a family be covered by health insurance before an adult may use the subsidy. Applicants to this program are advised that their children may be eligible for OHP Medicaid or CHIP coverage at no cost. Despite this fact, children under 19 represent one-third the FHIAP population even though they would presumably qualify for no-cost, comprehensive public coverage. This would indicate that some families prefer private sector coverage even when it involves cost sharing. This may be because families perceive a stigma attached to welfare programs or they may prefer to insure all family members under one source of coverage. Children covered by FHIAP totaled 1,826 on January 31, 2000.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

Table 4.1.1 CHIP Program Type _____						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	6,488	27,285	2.0	55.00%	95.2%	46.7%
Age						
Under 1	182	534	2.0	55.00%	95.1%	47.0%
1-5	1,449	6,426	2.0	53.00%	95.7%	45.1%
6-12	3,298	13,354	2.0	57.00%	95.1%	47.7%
13-18	1,559	6,971	2.0	55.00%	84.8%	46.2%

Table 4.1.1 CHIP Program Type

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Countable Income Level*						
Age and Income						
133-170% FPL (<1 yr)	182	534	2.0	5.5	95.1%	46.7%
133-170% FPL (1-5 yrs)	1,449	6,426	2.0	5.3	95.7%	45.1%
100-170% FPL (6-12 yrs)	3,298	13,354	2.0	5.7	95.1%	47.7%
100-170% FPL (13-18 yrs)	1,559	6,971	2.0	5.5	94.9%	46.2%
Type of plan						
Fee-for-service	1,872	4,098	1.6	4.9	96.5%	48.4%
Managed care	4,548	22,581	2.1	5.7	94.6%	46.5%
PCCM	68	606	1.6	4.6	95.6%	41.9%

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

> **4.1.2   How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))**

CHIP applicants with private insurance within the past six months are not eligible for CHIP with certain exceptions. See Section 3.6.2 Monitoring Crowd Out

> **4.2.3   What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)**

See Table 1.3-A

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

To facilitate continuous health care coverage for eligible children, approximately 45 days before Medicaid/CHIP coverage ends, the OHP application processing center sends a notice and a new application to enrollees notifying them that their coverage is scheduled to end soon. Enrollees receive a total of three notices before coverage is terminated. Because of the high mobility of the population receiving OHP benefits, the application processing center implemented a program in 1998 to locate clients who may have moved.

> 4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

Oregon has made substantial progress in expanding health care coverage for children. In 1991 21% of Oregon's children were uninsured, by 1998 that number had been reduced to 9.5%[1]. This has been achieved through a combination of factors, including:

In 1989, Oregon implemented a small business insurance pool program which insured 5,738 lives as of November 30, 1999.
The July 1998 implementation of the Family Health Insurance Assistance Program (FHIAP) an insurance subsidy program which covers families with incomes up to 170% of the FPL. FHIAP currently covers 5,586 lives, approximately one-third of which are under age 19.
In 1993 and again in 1996, insurance market reforms were written into law eliminating certain industry practices that acted as impediments to coverage for a sector of the group health insurance market.
More than 15,000 Oregonians who had previously been denied coverage due to pre-existing conditions have obtained coverage through the Oregon Medical Insurance Pool
During the period 1989-1996 Oregon benefitted from public focus on the importance of health coverage during a period of steady economic growth and diversification.
The percentage of insured adults who receive health insurance from an employer rose from 56% to 70% between 1994 and 1998.
500,000 people in Oregon have received health insurance due to the Medicaid Expansion.

The combined efforts form Oregon Health Plan's Core Principles and Strategies to increase access to health care leading to improved the health of all Oregonians:

A Public – Private Partnership
The partnership between the public and private sectors is fundamental to Oregon's health policy reforms. The OHP attempts to stabilize and strengthen this partnership. The public and

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[1]The Uninsured in Oregon 1998, Office of Health Plan Policy and Research

private sectors share responsibility for financing health care for different classes of citizens.

Improvement in Health Status

\#   The OHP attempts to maintain or improve health status, not merely to provide health care. Because studies have shown that high health care utilization does not always achieve positive outcomes and that all health care interventions are not equally effective, Oregon purchasers support strategies that focus on providing the most appropriate and effective health care services.

Reliance on Market Forces

\#   Market forces can stimulate innovation and effectiveness. The OHP relies on Oregon's traditionally innovative health care marketplace to deliver value to Oregon consumers.

Promoting Health Care Systems for Managing Care

The OHP relies upon managed health care as a strategy to improve health status, assure health care access and quality and reduce the rate of growth in health care costs.

Shared Economic Risk

     1Just as health care delivery has moved from an unstructured model to one of managed systems of delivery, the financing of health care has evolved from fee-for-service to a wide variety of approaches with shared economic risk with physicians, hospitals and other providers. Risk sharing strategies are attempts to align clinically appropriate levels of care with prospective estimates or fixed per capita payments.

4.2   Who disenrolled from your CHIP program and why?

       4.2.1   How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

Disenrollment from CHIP has been higher than expected. Since its inception in July 1998, Oregon's CHIP program has served a total of 28,367 children with enrollment of 15,173 on September 30, 1999. Due to a high number of disenrollees from the program, Oregon did not meet its targeted enrollment of 16,800 children by July 1999. While on average OMAP enrolls just less than 5,600 children into the CHIP program quarterly (see Table 4.2.1), approximately 4,000 children disenroll during the same time period.

See Table 1.3-A

Table 4.2.1
NEW CHIP Enrollees
Number of New Enrollees Per Quarter
Program Status Previous Quarter

Previous Quarter	Qtr End 9/30/98	Qtr End 12/30	Qtr End 03/31	Qtr End 06/30	Qtr End 09/30	Total	Rate
Medicaid	2983	3056	2537	2681	3518	14775	53.0%
Non-Medicaid	3267	2538	2600	2327	2381	13113	47.0%
Total New CHIP Enrollees	6250	5594	5137	5008	5899	27888	

Source: Office of Medical Assistance Programs

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

See Section 4.2.1. Data not available on children who left OHP.

4.3   How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998: 482,919

FFY 1999:   9,568,743

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type _____				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	482,919	9,568,743	352,423	6,933,149
Premiums for private health insurance (net of cost-sharing offsets)*	n/a	n/a	n/a	n/a
Fee-for-service expenditures (subtotal)	202,894	2,633,844	148,035	1,907,926
`Inpatient hospital services	127,513	666,059	93,111	482,520
Inpatient mental health facility services	n/a	n/a	n/a	n/a
Nursing care services	n/a	n/a	n/a	n/a

Table 4.3.1 CHIP Program Type

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Physician and surgical services	21,670	459,779	15,822	333,123
Outpatient hospital services	20,383	393,388	14,883	284,961
Outpatient mental health facility services	2,877	65,523	2,100	47,451
Prescribed drugs	25,333	272,691	18,495	197,556
Dental services	2,749	25,116	2,006	18,199
Vision services	647	20,662	362	14,967
Other practitioners' services		440		319
Clinic services		582,804		422,085
Therapy and rehabilitation services	112	16,006	82	11,587
Laboratory and radiological services	n/a	n/a	n/a	n/a
Durable and disposable medical equipment	431	41,520	314	30,052
Family planning	436	32,223	318	23,360
Abortions	n/a	n/a	n/a	n/a
Screening services	n/a	n/a	n/a	n/a
Home health		55		40
Home and community-based services	n/a	n/a	n/a	n/a
Hospice	n/a	n/a	n/a	n/a
Medical transportation	72	19,282	53	13,957
Case management	671	38,296	490	27,749

Table 4.3.1 CHIP Program Type				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Other services	n/a	n/a	n/a	n/a

4.3.2 **What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.**

What types of activities were funded under the 10 percent cap?

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach			included in Medicaid			
Administration			53,677	359,711		
Other						
Federal share						
Outreach			included in Medicaid			
Administration			39,195	260,359		
Other _____						

4.3.3 **What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))**

    X State appropriations
    ___ County/local funds
    ___ Employer contributions
    ___ Foundation grants
    ___ Private donations (such as United Way, sponsorship)
    ___ Other (specify) _____

4.4   How are you assuring CHIP enrollees have access to care?

4.4.1   What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system withing each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits			
PCP/enrollee ratios			
Time/distance standards		X - MCO	
Urgent/routine care access standards		X - MCO, PCCM	
Network capacity reviews (rural providers, safety net providers, specialty mix)		X - MCO, PCCM	
Complaint/grievance/ disenrollment reviews		X - MCO, PCCM, FFS	
Case file reviews		X - MCO, PCCM, FFS	
Beneficiary surveys		X - MCO, PCCM, FFS	
Utilization analysis (emergency room use, preventive care use)		X - MCO	
Other (specify) On-Site, Quality Improvement Program Evaluations of Health, Dental & Chemical Dependency Managed Care Plans		X	
Other (specify) _____			
Other (specify) _____			

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	___ Yes ___ No	X Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	X Yes ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Our data indicate that in 1998, 82% of Oregon CHIP enrollees (Modified HEDIS, includes all ages) who were continuously enrolled in OHP received at least one visit to a Primary Care Practitioner. This compares favorably to NCQA's Quality Compass rates of 80.3% to 89.9% (rates vary by age group).

Table 4.4.3
Rate of Primary Care Visits 1998
Children <19 y.o.

	# of Children All Ages Continuously Enrolled	# of Children All Ages Receiving Primary Care Visits	% Receiving Primary Care
CHIP	1673	1376	82%
OHP Total	43457	34717	80%

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

OMAP will continue to report the modified HEDIS Access to PCP measure to monitor access to primary care. In addition, a representative sample of CHIP enrollees will be included in the 2000 Consumer Assessment of Health Plan Study (CAHPS) to monitor access to health care.

4.5   How are you measuring the quality of care received by CHIP enrollees?

   4.5.1   What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.

Oregon's CHIP program is integrated seamlessly with Medicaid and is part of a well-established Continuous Quality Improvement (CQI) program.

Components of this program include:

On-Site Quality Improvement Program Evaluations

MCO programs and systems are evaluated bi-annually through both site review and desk audit to assure OHP members have access to high-quality health care tailored to the needs of the populations served. In addition to monitoring compliance to administrative rules, these on-site evaluations are an opportunity for OMAP to identify and share best practices with MCOs. The previous cycle of reviews and reviews of all new MCOs include a review of: adequacy of current policies and procedures for member care; care for special needs populations; review and coordination of medical records; appropriateness of preventive, primary and specialty services utilization; timeliness and appropriateness of referrals; appointment monitoring; arrangements for emergency services and the after-hours call-in system; review of service denials, including assessment of comorbidities; plan initiated disenrollment; quality of the ENCC program; and member education.

The focus of the next cycle of health plan reviews is preventive services, member education, compliance with directives and standards, and community partnerships. Specific domains for evaluation will include: overall QI program; utilization management program; chronic disease management; ENCC services; services to children with special health care needs; coordination with other services such as dental, mental health and chemical dependency treatment providers; tobacco cessation strategy; cultural competency; maternity care; and well-child visits.

External Quality Review
Children enrolled in CHIP will be included in future External Quality Review Organization (EQRO) studies as part of the sampled population, although the review will not over sample for CHIP-specific studies. The current EQRO studies which include records from April 1997 through March 1998 focused on well-child visits, adolescent and adult depression and adult diabetes. As with performance measures and surveys, results from these EQRO studies will be used in OMAP's CQI program.

Performance Measures

Health Plans are currently required to annually report HEDIS Childhood Immunization Status and Initiation of Prenatal Care. In addition to plan reported measures, OMAP currently conducts plan and state specific Medicaid/CHIP HEDIS measures collected from encounter data. Results of these measures will be used in OMAP's CQI program.

Member Surveys

Through the use of the Consumer Assessment of Health Plan Survey (CAHPS), OHP members are regularly surveyed for access to and satisfaction with health care. OMAP will use the CAHPS 2000 survey, over sampling parents of children enrolled CHIP, to provide CHIP specific information. In addition to the CAHPS survey, OMAP and its partners conduct other OHP member surveys as needed to address specific issues or concerns. These ad-hoc surveys have included parents of children with special health care needs and aged, blind and disabled adults.

Project: **PREVENTION!**

Project: **PREVENTION!** (PP) is a management and quality initiative undertaken on behalf of OHP members. PP was initiated in the spring of 1996 by OMAP and the Oregon Health Division in partnership with managed health care plans. Because prevention is a critical basis of an effective service delivery system, an integrated and targeted effort was implemented to improve the delivery of managed health care services to OHP members. Previous and current PP efforts include: the development of a statewide immunization registry, smoking cessation projects and early childhood cavities prevention.

Table 4.5.1			
Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)		EQRO studies, Well-Child Visits, Child Dental Visits and Teen Depression. As part of OHP Quality Management Program	
Client satisfaction surveys		CAHPS 2000	
Complaint/grievance/ disenrollment reviews		Yes, as a part OHP Quality Management Program	
Sentinel event reviews			
Plan site visits		As part of OHP Quality Management Program	
Case file reviews			
Independent peer review		EQRO	
HEDIS performance measurement		Well Child, Access to PCP, Immunizations as part of OHP Quality Management Program. Specific CHIP modified HEDIS measures for Well-Child Visits and Access to PCP as well.	
Other performance measurement (specify)			
Other (specify)			
Other (specify)			
Other (specify)			

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

OMAP used a modified HEDIS Well-Child Visit measure as an indicator of the quality of health care for children enrolled in CHIP. Oregon's encounter data indicates the rate for well child visits for 3 to 6

year olds enrolled in CHIP is 33%[2] (46% adjusted[3]). This rate is below our targeted Healthy People 2000 Goal of 80%, however the adjusted rate does compare favorably with NCQA's Quality Compass rate of 51%.

Well-Child and Well-Care Visits for Adolescents are a focus of OHP's upcoming 2000/2001 cycle of on-site MCO quality improvement evaluations. Increasing the number of children and adolescents receiving well-care visits, as well as improving the quality of the visit will be one of the objectives of these on-site evaluations.

The reported figures are estimated to be slightly under-reported due to encounter data omissions. Because of the newness of the program, the denominator consisted of children who were continuously enrolled in an OHP FCHP (as defined by HEDIS) and eligible for CHIP any time in 1998.

Table 4.5.2
Rate of Well-Child Visits: 3 to 6 Y.O.

	# of Children 3 to 6 Years Continuously Enrolled	# of Children 3 to 6 Years Receiving Well-Child Visits	% Receiving Well-Child Visits
CHIP	562	188	33%
OHP Total	16259	6203	38%

Source: Office of Medical Assistance Programs

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

Well-Care Visits for Children and Adolescents are a focus of OHP's upcoming 2000/2001 cycle of on-site, MCO quality improvement evaluations. Increasing the rate of well-care visits for children and adolescents, as well as improving the quality of the visit will be the objective of these on-site evaluations.

OMAP will continue to monitor quality of health care received by CHIP enrollees by collecting and reporting HEDIS Well-Child Visits and Childhood Immunization Status for children enrolled in CHIP. In addition, a representative sample of CHIP enrollees will be included in OMAP's 2000 CAHPS survey.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list

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[2]Due to the newness of the program, the denominator consisted of children who were continuously enrolled in an OHP FCHP (as defined by HEDIS)

[3]Adjusted rate reflects encounter data omissions

attachments here.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 **What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)**

5.1.1 Eligibility Determination/Redetermination and Enrollment

By designing CHIP through the existing structure of Oregon's Medicaid 1115 Waiver, the CHIP application, eligibility determination and redetermination processes were not only simple to implement but coordination between the two programs has been high.

The single application and eligibility determination process ensures that mixed eligibility households are all enrolled under OHP. For example a household at 125% FPL might consist of a pregnant mother and 3-year old child on Medicaid, while the 7-year old child would be on the CHIP program. However, all would be enrolled in the same health plan.

Another benefit to the combined Medicaid and CHIP programs is the increase in continuity of care that the children receive. As demonstrated in this evaluation, there is much movement between the CHIP and Medicaid program as household incomes fluctuate. If these programs were operated separately, those families whose incomes fluctuate between above and below 100% of FPL would lose that continuity of coverage as they moved into and out of separate programs. If a separate application and eligibility determination process was used, it is likely that would create an additional barrier to coverage.

While OMAP has realized many benefits by operating CHIP within the Medicaid system, some families may not enroll their children if they perceive stigma attached to the OHP.

Because Oregon's CHIP program is fully integrated into the existing 1115 Medicaid waiver, the internal structure and systems are in place to perform high levels of evaluation. Evaluation includes quality management.

The Office for Oregon Health Plan Policy (OOHPPR) and Research is conducting information sessions around the state soliciting feedback on improving the Oregon Health Plan. The Medicaid Advisory

Committee membership is composed of administrators of public agencies, managed care organizations and OOHPPR meets bi-monthly to discuss Medicaid issues.

Because Oregon has Title XXI allocation dollars available it makes sense to use as a way to strengthen the public private partnership of health coverage by expanding children's coverage under the FHIAP program.

5.1.2 Outreach

Oregon's CHIP outreach efforts have been limited due to its integration with the Medicaid program. One drawback in operating CHIP within the Medicaid system, is the difficulty in targeting children specifically with outreach efforts. Because CHIP and Medicaid share the same application which requires listing all members of the household, outreach efforts will bring in Medicaid eligible adults as well as children.

Oregon will continue to support the Outreach Facilities that are currently in-place as well as the Covering Kids outreach pilot projects as resources are available to fund CHIP. However, since CHIP is nearing its ceiling funded by the 1997 Oregon legislature, additional outreach efforts at this time would not be advisable.

5.1.3 Benefit Structure

Consistent with Oregon's philosophy of expanded access to high quality, affordable health care, parents of children enrolled in the Oregon Health Plan are generally quite satisfied with their access to and quality of health care services.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

Because Oregon charges no premiums or co-pays on children's CHIP coverage, the cost of coverage should not be an issue. However, parents with outstanding premiums owed to the OHP may be reluctant to apply for coverage for their children.

5.1.5 Delivery System

Three-fourths of the OHP population are enrolled in MCOs with the remainder receiving services through Fee-For-Service providers or Primary Care Case Managers. As has been seen throughout the country, access to health care in rural regions can be problematic. Oregon will continue to closely monitor access and appropriate utilization of health services for clients living in these regions.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

As discussed in Section 4, the State of Oregon has a notable history of private sector, collaboration and partnerships.

5.1.7   Evaluation and Monitoring (including data reporting)

As reported in Section 4.5, Oregon has a very strong program to evaluate, monitor and improve the delivery of appropriate health services to all OHP clients. Oregon has focused attention on children's health needs because of the impact high quality, preventive health care has on children's health throughout their lives.

Because the OHP CHIP program is fully integrated into the existing 1115 Medicaid waiver, the internal structure and systems are in place to perform high levels of evaluation and monitoring of access to and quality of health care (see Section 4.5).

5.2   What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

See section 5.3

5.3   What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

Oregon is well ahead of many states in its efforts to provide high quality, cost effective health care coverage for children. While 16% of U.S. children were uninsured, Oregon's rate was significantly lower -- under 10% in 1998. However, many factors could negatively impact our success. A downturn in Oregon's strong economy, health care price inflation and continued movement of providers out of Oregon's rural regions could result in serious consequences for both children and adults.

Governor John Kitzhaber's January 2000 "State of the State" speech called for Oregon to continue moving towards coverage of all its 3.2 million residents. Currently 300,000 Oregonians lack health care coverage. The Governor and Oregon legislators are seeking public input to help shape Oregon's health care system. Beginning in April, a series of meetings will be conducted throughout the state. These meetings are sponsored by the Oregon Health Council, the Oregon Health Services Commission, the Health Resources Commission, the Medicaid Advisory Committee, and the Office for Oregon Health Plan Policy and Research.

Section 5.1.1 notes that "While OMAP has realized many benefits by operating CHIP within the Medicaid system, some families may not enroll their children if they perceive a stigma attached to the OHP." Along with many other states, Oregon has been exploring ways to partner with employer-sponsored insurance to enroll more children in CHIP. However, Oregon has found that current Federal CHIP requirements create barriers to such efforts.

Oregon provided detailed suggestions on this issue in OHPPR's comments on HCFA's proposed Implementing Regulations for the State Children's Health Insurance Program. The primary concern is that HCFA's approach to implementing CHIP seems to apply primarily to publicly operated CHIP

programs. HCFA standards related to private sector health insurance seem to assume that the state will directly contract with such health plans. This is not the case in an employer-sponsored insurance model. HCFA's standards related to benefits, cost-sharing, premiums, substitution of coverage, and other issues should be modified to recognize and facilitate the development of employer-sponsored insurance models for CHIP.

Sources:

Office of Medical Assistance Programs

Office for Oregon Health Plan Policy and Research

Children in the Oregon Health Plan: How Have They Fared? Janet B. Mitchell, et. al., Health Economics Research.

Oregon Department of Consumer and Business Services, Insurance Pool Governing Board

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